Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ERADIO ARREDONDO, MD
P.O. BOX 741865
DALLAS, TX 75374

Respondent Name

ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-11-1110-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUIRED TO PAY DD EXAMS."

Amount in Dispute: $827.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A copy of dispute was placed in carrier rep box on December 08, 2010 with no response to MFDR.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 08, 2010	99456-RE-W6, 99456-RE-W9 and 95831	$827.50	$827.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. 28 Texas Administrative Code §134.203 sets out Medical Fee Guidelines for professional services effective March 1, 2008.
4. Explanation(s) of benefits were not provided by either party to the dispute.

Issues

1. Has the Designated Doctor examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor rendered multiple DD exams as ordered by the Division. The provider billed $500.00 for CPT code 99456-RE-W6 in determination of extent of injury (EXT) per 28 Texas Administrative Code §134.204(i)(1)(C). The requestor also billed $250.00 for CPT code 99456-W9-RE to address whether there is an injury related to the claimed incident per 28 Texas Administrative Code §134.204(i)(1)(F). Review of documentation supports that the Division ordered both of these examinations which are payable per Texas Labor Code §408.0041(h). Per 28 Texas Administrative Code §134.204(i)(2)(A) & (k), the MAR for the 1st examination is $500.00. Per 28 Texas Administrative Code §134.204(i)(2)(B) & (k) the MAR for the 2nd examination is 50% of MAR which is $250.00. The combined MAR for the DWC ordered examinations is $750.00. Muscle testing was also performed as allowed by 28 Texas Administrative Code §134.204(k). The MAR calculation for the 2 units of CPT code 95831 is reimbursed according to 28 Texas Administrative Code §134.203(c)(1) with a service location of Corpus Christi, TX in zip code 78414 (Nueces County-REST OF TEXAS) with a MAR of $77.66.
2. The total MAR is $827.66 and the requestor seeks $827.50. No payment has been made per the Table of Disputed Services; therefore $827.50 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $827.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $827.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 23, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.